WISCONSIN STATE ASSEMBLY

PEGGY KRUSICK
STATE REPRESENTATIVE

Nursing Home Violation Reporting (AB 389)

This legislation would require families to be notified when a nursing home is cited by state regulators if their loved one is included in a serious state citation issued by the Department of Health Services (DHS) following an inspection of the nursing home. It was drafted in consultation with DHS and state aging advocates.

Right now a nursing home can be fined or otherwise sanctioned by DHS for violating state rules or regulations if DHS determines that a resident's injury or death results from the nursing home's actions, and the family might never know a citation was imposed. In fact, an extensive Milwaukee Journal Sentinel investigation last year found dozens of nursing homes in Wisconsin had been cited for improper care after the deaths of 56 residents since 2005. However, according to the report, several families never knew the nursing homes where their loved ones died had been issued violations for serious problems until after the newspaper contacted them.

The Bill
Requires within 15 days of receiving a class "A" violation or a federal finding of Immediate Jeopardy that a nursing home provide written notice to the resident, or to the resident's legal representative, of each resident identified in the citation.

Specifies that the written notice shall include the following:
- The anonymous identifier used to designate the resident in the violation notice.
- Contact information for the Division of Quality Assurance (DQA) regional office assigned to the facility.
- Information that DQA will be able to provide a copy of the citation upon request to the resident or their legal representative.

Provides a maximum $2,500 penalty for nursing homes that fail to comply.

Rationale
When a nursing home is cited after something very bad happens to a resident, the family has a right to be notified. This legislation makes citations for serious nursing home violations more transparent and establishes a process for families to easily obtain this information. (A summary of Immediate Jeopardy citations issued to Wisconsin nursing homes in the past year is attached).

Supporters
AARP Wisconsin
Wisconsin Board on Aging and Long-TermCare
Disability Rights Wisconsin
Legal Aid Society of Milwaukee

SUMMARY OF IMMEDIATE JEOPARDY CITATIONS IN WISCONSIN 7/1/08 to 7/21/09	
F314	Resident with contracted arms developed a stage 4 pressure ulcer inside the elbow that exposed the tendon. Staff had placed a sleeve on the elbow and had not recognized that this created additional pressure. Staff did not perform daily range of motion and did not daily clean the area, which might have allowed for earlier detection of the pressure ulcer.
F224	Resident repeatedly was found with his hands on the body of other residents. Despite 25+ incidents in a two-week period, staff had not implemented measures to better ensure the safety of other residents.
F314	Resident developed a stage 4 pressure ulcer underneath a leg mobilizer. Staff had not monitored the area after a stage 2 pressure ulcer had been identified.
F441	One-third of residents on one unit were actively coughing or had nasal secretions but were allowed to intermingle with residents who were not ill. Residents with known pneumonia were encouraged to be out and about. Facility was not tracking illnesses and was not aware that 11 residents had developed in-house pneumonia in the last couple of weeks.
F226	Facility did not implement procedures to protect residents after a resident accused a CNA of having sexually assaulted her and after a CNA told the resident that he had sexually assaulted 2 or 3 other residents.
F224	Resident who could quickly become volatile and explosive had at least 18 incidents of aggression towards other residents in 2 months. These included holding a knife at the throat of a resident, pushing residents to the floor, grabbing residents, and striking out. Staff did not implement approaches to ensure the safety of residents.
F309	RN directed an LPN who had started CPR to stop, before the paramedics arrived. RN was not aware that the resident was full code.
F327	Resident was admitted to the hospital acutely ill with abnormal lab values, and had become increasingly lethargic and confused while at the facility. Facility had not implemented changes when fluid intake was less than assessed need and when the resident developed multiple loose stools due to c-diff.
F441	Gastrointestinal illness "spread like wildfire" resulting in the need for IV hydration for at least one resident. Staff were not tracking and trending the illness, had not recognized the outbreak in its early stages and had not implemented measures to keep it from spreading. Facility did not give direction to ten staff that were sick as to when they could return to work.
W466	16 clients received poached eggs and were placed at risk of salmonella illness. Eggs were not pasteurized and had not been cooked at 145 degrees for at least 15 seconds.
F323	Resident fell and sustained a fractured femur after being placed in her room by a volunteer without a required safety alarm. Facility did not have policies and procedures that identified for its extensive volunteer staff who was at high risk for falls.
F333/F281	Staff failed to correctly transcribe an order and, consequently, failed to give Coumadin throughout the resident's three week stay. Ten days after being discharged home the resident was admitted back to the hospital with multiple pulmonary emboli and deep vein thrombosis.
F441	7 of the facility's 61 residents developed influenza and 77% developed noro-virus like symptoms in 2008. Facility had not implemented procedures to track and trend the illness or to reduce the spread of infection. Facility, during survey, was unaware of a potential outbreak of pneumonia, which affected seven to eight residents.
F314	Resident developed a stage 4 pressure ulcer, which the facility had not identified until it had reached this stage. The facility did not get the medications to treat the area until three days after ordered and did not routinely assess the area or implement appropriate procedures to promote healing. The pressure ulcer increased in size and became infected.

SUMMARY OF IMMEDIATE JEOPARDY CITATIONS IN WISCONSIN 7/1/08 to 7/21/09	
F371	Four residents were placed at risk of salmonella poisoning when they were served unpasteurized eggs that had not been cooked at 145 degrees for at least 15 seconds.
F309/F157	Resident became stuporous and lethargic three hours after having fallen and hit her head. Staff did not assess the resident and did not do all the required neuro checks. Resident remained that way throughout the night. Resident's eyes were fixed and she failed to respond to a sternal rub at 7 the next morning but staff did not contact the MD. Routine labs, which came back at 1 PM, identified a panic low blood sugar level. Resident was transferred to the hospital but died at the hospital from anoxia due to hypoglycemia.
F373	Two residents at high risk for choking or aspirating were placed at risk for harm when fed by 2 feeding assistants.
F323	One resident fell ten times during a 50-day period and another fell 12 times in a six-month period. Staff made no changes in the residents' care plans and no changes to the amount of supervision they received.
F329	Resident, who was on Coumadin, developed bleeding over a period of three days, which was not communicated to the physician. Staff continued giving Coumadin. On day 4, when the resident's Protime was extremely elevated, the MD ordered vitamin K given immediately. This was not done until three hours later when staff realized that no one had given it. Resident was transferred to the emergency room and required two units of blood.
F329	Resident was placed at risk for spontaneous bleeding or major hemorrhage when facility staff administered Coumadin even after receiving a fax that the resident's Protime was critically high. Staff then continued to give Coumadin over two of the next three days even though the physician had ordered that it be held. Staff also failed to ensure that two lab tests were completed and the resident continued to have an elevated Protime.
F327	Three residents developed dehydration, one of whom died in the hospital where he had received five liters of fluid. Facility did not have a system to identify intake or to determine if intake was sufficient to meet assessed need.
F223/F225/ F226	A confused female resident unable to give consent was repeatedly sexually abused by her husband. Staff did not keep the resident free from abuse, did not promptly report allegations of abuse, and did not put measures in place to prevent further potential abuse.
F373	Resident with a history of aspiration pneumonia (3 occasions) was placed at risk of choking or aspirating when fed by a paid feeding assistant. Resident was not eligible for this service. Feeding assistant thought she could feed anyone.
F314/F250	Resident developed an eschar-covered area on the right ankle, which the facility did not identify until it had reached this point. An MRI two months later showed that the area had become infected with osteomyelitis but staff did not report this to the MD until four weeks later, during which time the infection went untreated. Facility did not develop an individualized care plan for treating the pressure ulcer and did not follow through with the recommendation by a psychologist to determine if the resident was competent to refuse treatments.
F327	Resident was admitted to the emergency room unresponsive two times with a diagnosis of dehydration. Facility did not implement measures to ensure that fluid intake was meeting assessed need, even after returning from the first hospitalization.
F323	Resident fell 13 times in 5 months with no investigation of root cause and no changes to the care plan, beyond identifying measures that were already supposed to be in place. Another resident fell 10 times in two months despite being on one-to-one observation. Staff admitted to not knowing how this was to be carried out.
F441	In a two week period, five residents developed fevers and gastrointestinal symptoms and three residents developed upper respiratory symptoms, two of whom had pneumonia and died. Facility did not have a system whereby it was able to contemporaneously identify

SUMMARY OF IMMEDIATE JEOPARDY CITATIONS IN WISCONSIN 7/1/08 to 7/21/09	
F223	Male resident, who had been perseverating about sex, raped a female resident, after being left unattended while a nurse went to get a new medication that had been ordered for him.
F327	Three residents became dehydrated, one of whom was transferred unresponsive to the nursing home and was diagnosed with severe dehydration. Facility did not have a system by which it ensured that residents were receiving fluids sufficient to maintain hydration or by which it was able to identify when significant deviations from assessed need were occurring.
F371	Resident was served an unpasteurized egg product; staff had not ensured that the egg yolk had reached a temperature of 145 degrees for at least 15 seconds.
F323	Four residents sustained repeated falls with injuries that included a wrist fracture. Staff had not assessed the falls and continued to implement approaches that had already proven to be ineffective in preventing falls (e.g., 15-minute checks or "keep in sight," which is difficult to do when only one CNA was scheduled for the unit.
F323	Eight residents had repeated falls. The facility did not systematically assess the falls to identify the root cause and did not revise its approaches to prevent further falls. "We don't know what else to do; we are using the alarms." One resident is now non-weight bearing after sustaining a fractured femur. Another required transfer to a specialty hospital because of a head injury sustained from a fall.
F309/F157/ F281	Resident's condition declined from Thursday, when she was up and about and conversing, to Monday when she was lethargic, pale, thin, drooling, and had slurred speech. An RN did not assess the resident when told of the condition change on Sunday and no contact had been made with the physician until the surveyor prompted staff to call. Resident had panic level BUN and potassium levels and was immediately placed on IV fluids.
F333/F157	Resident developed an acute adrenal crisis after the facility failed to transcribe and failed to give a medication that cannot be stopped abruptly. Staff did not immediately contact the MD five days later when the condition change was identified and the med error discovered. Resident became comatose and required transfer to the hospital, where MD indicated that she could have died.
F441	37 of 60 residents in 28 of 35 second-floor rooms developed gastrointestinal symptoms. There was no contemporaneous tracking of the illness, thus staff had not realized the extent to which it had spread. Ill residents were not kept separate from residents who were not ill and staff who had been sick were allowed to come back as soon as symptoms had ceased. Housekeeping staff were not using a bleach solution in rooms where residents were sick.
F323	A mildly confused resident with an activated power of attorney for health care laid outside in the rain in 37 degree weather for approximately 3 hours before staff realized that the resident was missing. Facility did not have a system for more closely monitoring her whereabouts.
F323	A confused resident eloped from the facility four times in 1 ½ months. The last time, the facility was notified of the resident's whereabouts by a business one to two blocks from the facility. A door that had been checked as "locked" one-half hour earlier was really unlocked. 15-minute door checks were subsequently implemented on only unit.
F309	A full-code resident was found unresponsive and staff failed to implement CPR procedures.
F314	A resident required surgery after developing a stage 4 pressure ulcer, with no changes to the care plan as the pressure ulcer increased in size. Recommendation for a Roho cushion was not implemented until one month later and a turning schedule was not observed being implemented.

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F365	Resident received a general diet rather than mechanical soft and began choking on a sausage patty. Instead of immediately performing the Heimlich maneuver, the resident was taken to his room where it was observed that the resident was now fully obstructed. The third attempt at the Heimlich maneuver was successful.
F224	Six residents on a 16-bed Alzheimer's unit were identified as having repeatedly abused other residents on the unit, including hitting, grabbing, pushing to the floor, spitting at, throwing objects and furniture and, on one occasion, punching a resident in the eye. Facility separated residents but did not work at developing proactive approaches for preventing/reducing such incidents
F225	Resident who was on oxygen on a vent unit sustained anoxic brain damage when the O2 system failed and residents were moved to portable oxygen. Resident was pulseless and non-breathing when found two hours after being put on portable oxygen. EMTs were mistakenly turned away when they first arrived at the facility. Facility did not investigate what occurred or put measures in place to prevent similar incidents in the future.
F323	Resident had repeated falls, 37 in seven months, two of which resulted in fractures (pelvis and hip). MD subsequently noted that the resident would continue to fall unless the facility used restraints or had someone sit with the resident. Facility did not implement closer supervision despite the fact that all previous attempts to prevent falls were not successful.
F323	Resident sustained facial fractures after being attacked and repeatedly kicked by two other residents. Despite a population of residents who are unpredictable and have explosive, impulsive personalities that led to 37 incidents of resident-to-resident abuse in six months, the facility was unable to provide care to protect residents in the facility.
F309	Resident was admitted to the hospital in an unresponsive state with intracranial bleeding over one-third of the resident's brain. Resident had fallen and hit his head the night before; staff failed to promptly assess over a period of 4-6 hours when resident displayed a significant change in condition.
F314	Resident required surgery after developing a stage 4 pressure ulcer with osteomyelitis. Resident was not seen by a wound team until 2 months after the recommendation; staff did not begin weekly assessments until one month after the pressure ulcer first developed and did not work with the resident or revise the care plan to address the resident's refusal of certain cares.
F323	Resident who was on Coumadin died after falling and striking her head. Prior to the fall, staff had not transferred the resident's alarm when the resident was transferred from the wheelchair to bed.
F441	GI illness spread throughout the facility; staff did not isolate residents who were sick from those who were not ill; did not implement contact precautions; did not accurately monitor, track and trend residents who were ill; did not ensure that staff working with residents were not ill or beyond the point at which they were no longer contagious; and continued to admit residents.
F224	Resident with an explosive, unpredictable personality had hit staff and residents, pushed a resident to the floor, and threatened to kill. Facility noted that staff and other residents were at risk but readmitted the resident after a psych evaluation without a sufficient plan for ensuring the safety of other residents.
F441	Approximately one-third of the facility's residents developed gastrointestinal symptoms and three developed pneumonia. Facility placed only residents on antibiotics on the infection control log but were not tracking and trending to identify outbreaks. Facility did not ensure that staff who were sick did not return to work until 48 hours after cessation of symptoms.

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F309	Resident died after falling and hitting head. Staff, which had acknowledged that alarms allowed them to get to the resident when he attempted to ambulate, forgot to activate the alarm.
F309/F157	Resident died after a nurse repeatedly ignored over an entire shift the resident's complaints of chest pain. There was no nursing assessment or MD contact.
F323	Resident sustained questionable frostbite and had a temperature of 95.4 after eloping from the facility when staff left unlocked and unalarmed an exit door at the end of the dementia unit.
F157/F329	Resident admitted to the hospital in critical condition with hemorrhaging into the chest after staff failed to alert MD of possible side effects of Coumadin and continued giving the medication.
F323	One resident fell 10 times in less than 2 months, necessitating a CT scan after one fall; another resident fell 12 times in six months. Staff did not always evaluate the falls and continued using approaches that had already proven ineffective in preventing or reducing the number of falls.
F225	Resident reported that she had been raped by a male CNA. The LPN did not immediately report this and no measures were put in place to ensure resident safety. CNA continued to work until resident's husband reported the allegation to a different nurse.
F157/F309	Resident had a critically low white blood cell count due to chemotherapy. Staff did not implement reverse isolation procedures and did not immediately inform the physician of this condition change.
F327	Resident admitted to the hospital with severe dehydration. Staff had not responded to the fact that the resident was consuming 545 cc's fluid/day when assessed need was between 1800 and 2000 cc's per day.
F250	Hmong resident who was unable to communicate needs to staff and who had infrequent visitors wrapped a cord around his neck three times as if to kill himself. Staff did not respond to the message behind these gestures and did not assess the resident or implement procedures to reduce his isolation and loneliness.
F373	Resident with complicated feeding problem was observed being fed by a staff employee who was not a paid feeding assistant.
F323	Resident had fallen over 50 times in the last half year, sustaining a fractured hip after one of the early falls. Staff did not assess the resident and continued using approaches that were proven to be ineffective or identified "new" approaches that were already supposed to be in effect.
F250	Residents and staff were hit, bit, and attacked by a resident that had frequent behaviors that were explosive and unpredictable, necessitating a 911 call on one occasion.
F224	Facility did not develop effective approaches for keeping other residents safe from a resident whose behavior was unpredictable and explosive and who would hit, kick, scratch, spit and swear and whom staff had identified as a danger to herself and others.
F323	Resident fell, struck head and subsequently died from the injuries sustained from a fall. Facility had not implemented its care plan to use alarms and to keep the resident in a lounge where she could be observed. Resident was alone in room with a nonfunctioning alarm.
F157	Resident, who was on digoxin, had a panic low potassium level, which can lead to cardiac irregularity and death. Facility did not inform the physician. No changes were made until the next day (a holiday) when the MD happened to be in his office and saw the panic level alert from the lab.
F157/F309	Resident on Coumadin developed a nose bleed. No assessment and no MD contact. Next dose of Coumadin given. That evening resident develops massive bruising and large hematoma to the arm but staff waited until the next day to notify MD. Protime and INR significantly elevated the next day; resident transported to the ER and started immediately on vitamin K.

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F314	Resident developed multiple stage 4 pressure ulcers with osteomyelitis. Facility had not assessed degree of risk, had not developed and implemented a care plan that addressed the risk factors and resident's noncompliance with positioning and had not monitored skin on an ongoing basis.
F323	Staff did not activate door alarm. Resident left unit after 10:45 PM and was found walking along the highway without a jacket or gloves when temperature was 29 degrees.
F323/F309	Resident died from injuries sustained after a fall, the third fall in 1½ months that occurred after personal safety alarm had not been activated. After the last fall, the evening nurse did not inform the night nurse of the fall and the fact that the resident had hit her head. No monitoring occurred for 6 ¾ hrs after the resident had fallen and hit her head.
F309/F281	Facility began giving AB+ blood to a resident who was O+, without having double checked to ensure that the right product was going to the correct resident. Mistake was not realized until 30 minutes later when the O+ blood arrived at the facility.
F309	Nurses did not perform CPR on a full-code resident who had a witnessed arrest in front of staff.
F323	Confused resident who required extensive assistance with ADLs sustained 3rd degree burns when she was left unsupervised after being given a cup of coffee, whose temperature staff had not checked prior to serving.
F441/F520	69 residents and 22 staff developed gastrointestinal symptoms, which included nausea, vomiting and diarrhea. Staff were not tracking and trending infections or keeping sick residents apart from those who were not sick. Staff not told to stay home until 48 hours after cessation of symptoms. QAA did not address at the meeting that occurred while the outbreak was occurring and had not discussed after an outbreak ten months earlier when 30 residents had gotten sick.
F441	One-third of the facility's residents developed gastrointestinal illness, during which time staff did not keep sick/well residents from intermingling, did not track and trend the outbreak, did not take steps to determine the causative factor, and did not implement appropriate handwashing and cleaning techniques.
F309	Staff delayed between 15 and 21minutes before giving CPR to a full-code resident who was found not breathing.
F309	Nursing did not consistently assess and evaluate a resident who had fallen and who, over the next four days, had bruising that extended further and further down the resident's face and neck. On day 4, when the resident was sluggish and slow to answer, no monitoring or assessment was done until 16 hours later. Resident was diagnosed with a T1 compression fracture.
F327	Resident, who required 2000 cc fluid per day, was admitted to the emergency room in serious condition related to dehydration, after consuming only 145-810 cc fluid per day over her first two weeks at the facility. Facility did not total fluid intake amounts each day, did not compare this with assessed need, and did not implement changes when significant deviations should have been identified.
F323	A resident, who has severe dysphasia and episodes of choking, and whose care plan called for a "soft" diet, was observed choking and coughing in his room (face red) while eating chips that he had been given as a prize in activities. Activity staff were not aware of special dietary needs of residents.
F441	30% of the facility's residents developed gastrointestinal symptoms. Infection control nurse only monitored residents on antibiotics, thus no tracking and trending was being done and no efforts were made to isolate residents on sick units from those in units that had not been infected. Staff were allowed to float between floors and no efforts were made to ensure that staff who were sick did not report to work or did not report back to work until 48 hrs. after cessation of symptoms.

SUMMARY OF IMMEDIATE JEOPARDY CITATIONS IN WISCONSIN 7/1/08 to 7/21/09	
	infections so that they could identify an outbreak and put procedures in place to reduce the spread. Residents who were ill were not kept apart from residents who were not; staff used only standard precautions, even with a resident who had c-diff; and housekeeping and laundry were not given special instructions for cleaning.
F314/F501/ F520	Over 10% of the facility's residents had facility acquired pressure ulcers and half of these had progressed to a stage 3. Surveyors identified problems with inaccurate assessments, generic care plans, failure to implement care planned approaches, and failure to evaluate progress. Medical director was aware of increase in pressure ulcers and asked QAA to follow; QAA did not and medical director did not follow up or provide further guidance.
F327	Resident was transported to the emergency room and admitted to the hospital in guarded condition after becoming so dehydrated that he had no urine output when catheterized. Staff had failed to push fluids (as ordered by the MD) or monitor intake after lab tests four days earlier had shown abnormal values indicative of dehydration.
F309	Resident was hospitalized for four days after requiring decompression of her abdomen after having had only one small bowel movement in six days. Facility did not implement its policies and procedures and did not assess the resident despite complaints of abdominal pain.
F490/F281	Facility did not implement standards of practice related to pressure ulcer care, pain management, pressure-ulcer treatment, administration of controlled-release narcotics, or duties that an LPN can perform by license.

Rose, Laura

From: Moran, Christian
Sent: Wednesday, September 09, 2009 1:57 PM
To: Rose, Laura
Subject: AB 259

Laura,

Here's the memo we prepared on AB 259. There's a link to Mary Zahn's story in the second paragraph.

Thanks,

Christian

389

Nursing Home Violation Reporting (AB 259)

This legislation would require families to be notified when a nursing home is cited by state regulators if their loved one is included in a serious state citation issued by the Department of Health Services (DHS) following an inspection of the nursing home. It was drafted in consultation with DHS and state aging advocates.

Right now a nursing home can be fined or otherwise sanctioned by DHS for violating state rules or regulations if DHS determines that a resident's injury or death results from the nursing home's actions, and the family might never know a citation was imposed. In fact, an extensive Milwaukee Journal Sentinel investigation last year found dozens of nursing homes in Wisconsin had been cited for improper care after the deaths of 56 residents since 2005. However, according to the report, several families never knew the nursing homes where their loved ones died had been issued violations for serious problems until after the newspaper contacted them.

The Bill
Requires within 15 days of receiving a class "A" violation or a federal finding of Immediate Jeopardy that a nursing home provide written notice to the resident, or to the resident's legal representative, of each resident identified in the citation.

Specifies that the written notice shall include the following:

- The anonymous identifier used to designate the resident in the violation notice.
- Contact information for the Division of Quality Assurance (DQA) regional office assigned to the facility.
- Information that DQA will be able to provide a copy of the citation upon request to the resident or their legal representative.

Provides a maximum $2,500 penalty for nursing homes that fail to comply.

Rationale
When a nursing home is cited after something very bad happens to a resident, the family has a right to be notified. This legislation makes citations for serious nursing home violations more transparent and establishes a process for families to easily obtain this information.

Supporters
AARP Wisconsin
Wisconsin Board on Aging and Long-TermCare
Disability Rights Wisconsin

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State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

Committee on Aging and Long-Term Care
Thursday, September 10, 2009

Otis Woods, Division Administrator for the Division of Quality Assurance
Assembly Bill 389
Nursing Home Notification Testimony

Good Morning, my name is Otis Woods and I am the Administrator for the Division of Quality Assurance within the Department of Health Services. My agency is responsible for the regulatory oversight of licensed health care facilities for State of Wisconsin and as a federal agent for the Centers of Medicare and Medicaid Services for facilities voluntarily participating in Medicare and Medicaid programs. I wanted to thank this committee and stakeholders in attendance for the opportunity to provide informational testimony on Assembly Bill 389.

Wisconsin has 397 nursing homes which are all regulated by the Department. Nursing homes are subject to unannounced inspections at least every 9-15 months, known as full recertification surveys. The Department also performs unannounced complaint surveys.

The goal of the full recertification survey is to evaluate systems, individual resident care, staffing and quality of life to determine if the provider is in substantial compliance with the minimum requirements to be licensed and participate in reimbursement programs. That full recertification survey includes an inter-disciplinary team of DQA staff that includes Registered Nurses, Health Service Specialists (such as a Social Worker, Activity Professionals and Nursing Home Administrators), Engineers as well as access to content experts at our central office, such as a Pharmacist or Registered Dietician. This full survey lasts several days, with some surveys making observations on weekends and all three shifts at the facility.

In 2008, the Bureau of Nursing Home Resident Care received over 1,330 complaints that warranted further investigation; for 2009, we are projected to have 1,750 complaints that warrant further examination. DQA, Office of Caregiver Quality, also received 1,540 self reports from Wisconsin Nursing Homes in 2008. Complaints and self-reports are reviewed and investigated through the on-site unannounced survey process.

There are five categories for state citations; going from highest to lowest in severity and subsequent enforcement:

1. Class A Violation
2. Class B Violation
3. Class C Violation
4. Correction Order
5. Notation

These violations are defined within Chapter 50. AB 389 addresses Class A violations. Class A violations are issued when "a condition or occurrence relating to the operation and maintenance of a nursing home presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom." Surveyors can issue a Class A violation when a resident has been seriously harmed by a deficient practice at the nursing home or when the resident has not yet been harmed but is at substantial risk that serious harm will occur.

Class A violations comprise a small percentage of total state violations issued.

- Of 670 state violations issued in 2008, 35 violations (5%) were Class A violations.

- Similarly, of 431 violations issued to date in 2009, 27 violations (6%) have been Class A violations.

Federal citations are issued based on the scope, or number of residents that are affected by the deficient practice (Isolated, Pattern or Widespread), and severity of the violation. CMS has 4 categories defining severity of the violation going from highest to lowest and subsequent enforcement:

1. Immediate Jeopardy
2. Actual harm
3. No actual harm with potential for more than minimal harm
4. No actual harm with potential for no more than minimal harm.

These definitions are found in the federal state operations manual. AB 389 addresses Immediate Jeopardy violations, which is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death."

An Immediate Jeopardy citation would be the highest severity level and could be found in three phases of scope (Isolated, Pattern or Widespread) based on the case specifics. Like Class A violations, surveyors can issue an Immediate Jeopardy citation when a resident has been seriously harmed by a deficient practice at the nursing home or when the resident is at risk that serious harm will occur in the immediate future.

By targeting Immediate Jeopardy violations, this bill applies to a very small subset of all the citations that DQA issues.

- In 2008, the Bureau of Nursing Home Resident Care issued a total of 2,824 federal citations, 76 (2.7%) of these violations were identified at the Immediate Jeopardy level.
- So far in 2009, 2,049 federal citations have been issued and 68 (3.3%) have been identified at the Immediate Jeopardy level.

In total, by targeting Class A and Immediate Jeopardy violations, less that 4% of all state and federal violations issued in the past 20 months are impacted by this bill (206/5,974).

When any violation is identified, DQA issues a document called the Statement of Deficiency (SOD). The federal contract requires, and internal DQA policy dictates, that a formal and specialized format is used when writing the SOD called the Principles of Documentation. The Principles of Documentation removes the specific identity of staff and resident names involved in any violations. Only the Facility Staff, DQA, and the Centers for Medicare and Medicaid Services are aware of the true identity of the residents involved in the violation.

Federal regulations require facilities to post the SOD in their facilities from the last recertification survey and all subsequent surveys. On average, this would be for the period of one year. The posted SOD does not identify who the residents were.

Current federal and state regulations require nursing homes to notify a family member or designated party when a resident's condition changes. Nursing homes must provide immediate notification of significant condition changes and "prompt" notification of non-significant changes. DQA monitors nursing homes to ensure that such occurs. Current laws, however, do not require nursing homes to inform a family member or designee that *facility practice* caused a serious condition change or placed the resident at risk of serious harm occurring.

AB 389 creates a mechanism to inform residents and legal decision-makers for residents when a resident was specifically involved in a Class A and/or Immediate Jeopardy level rule violation while residing at the nursing home. The SOD would need to be shared with the residents (and or legal decision-makers for residents) identified in the violation.

AB 389 obligates the nursing home provider community to inform specific residents and legal decision makers for the specific resident, that they were identified as an example of non-compliance for the highest level of state and federal violations as part of the nursing home inspection process conducted by the Department.

This bill also requires nursing homes to include the contact information for the DQA regional office that conducted the survey if they have questions about the SOD or want to know of the final outcome of the survey.

As a minor technical note, AB 389 would need to be modified to permit the Department to assess forfeiture for Class C violations. Currently, DHS does not have statutory authority to assess forfeitures for Class C violations under Chapter 50.

I thank you for the opportunity to provide informational testimony to this important audience. I would be happy to address any questions you have.

WHCA/WiCAL
Wisconsin Health Care Association Wisconsin Center for Assisted Living

To: Representative Peggy Krusick, Chair, and Members of the Assembly Aging and Long Term Care Committee

From: WHCA/WiCAL, Brian Purtell and Jim McGinn

Re: 2009 AB 389

Date: September 9, 2009

On behalf of the nursing home members of the Wisconsin Health Care Association (WHCA), the following comments are provided to the proposed 2009 AB 389. The WHCA opposes this bill for multiple reasons, chief among these is the fact that the actions it mandates will do nothing to promote or enhance the quality of care and services provided by Wisconsin's nursing homes. Moreover, the resources that will be expended to meet the bill's expectations will divert already strained staff and resources from resident care.

Notice of allegations is required prior to opportunity for facility to contest and exercise due process rights:

The obligation to provide copies of the SOD to residents alleged to be impacted by an Immediate Jeopardy (IJ) deficiency or Class A citation within 15 days of receipt of the allegation is a requirement would obligate such notice without the facility even having an opportunity to refute the allegation. Facilities would not even be able to conduct an Informal Dispute Resolution (IDR), much less a federal or state appeal for an allegation that is disputed, prior to having to provide a copy of and SOD that may contain allegations strongly contested by the facility.

SODs are drafted to support the alleged deficiency, and they are not intended, nor are they drafted, as a balanced depiction of the situation. Further, errors and omissions are made by surveyors, many of which would be modified or eliminated via IDR or administrative appeal. However, in many instances and appeal or IDR may not be pursued because need to allocate facility resources internally, as enforcement regulations compel facilities to focus on satisfying that corrections have been made in order to prevent or cease the imposition of significant penalties.

Compelling a facility to send countless SODs, for which they may strongly contest in whole or in part is counter to the basic notions of due process. The facility reputation and standing will be harmed, and residents/families may be needlessly concerned about

an allegation that may later prove to have been erroneously cited or containing incomplete or inaccurate information.

A likely, but unintended consequence of this bill is that facilities would be compelled to expend resources toward challenging every misstatement or allegations for which they disagree, thus increasing costs to both the providers and the regulators. Further, the already contentious survey process will be further strained by compelling facilities to provide copies of notices for which they disagree.

Compounding the problem further is the fact that IJ allegations can be issued for "the potential" for harm, i.e. alleged non-compliance *could have* lead to harm, but did not occur. Compelling a facility to provide notice to a resident/family, possibly months after the fact, that they were listed within the examples of individual who "might" have been harmed will not serve any purpose and raises the real possibility of causing needless fear or anguish. If for example, a facility was cited for alleged non-compliance related to a facility's response to a gastroenteritis outbreak, the SOD would likely indicate that most or all residents were exposed to the *potential* for harm, regardless of how many or few actually experienced symptoms. Under the bill, it appears that all residents would be required to receive a copy of the SOD.

Regulations currently require extensive notification and/or communication which addresses circumstances better than what AB 389 seeks to address:

The notice requirements contained within AB 389 are duplicative of the existing notification and communication requirements.

Replete through the state and federal regulations, *see,* Wis. Stats Ch. 50, Wis. Admin. Code DHS 132, 42 C.F.R. 483, are reporting/notification expectations by nursing homes, including, but not limited to:

- A facility must immediately notify the resident; consult with the resident's physician, and legal representative/family member when there is:
    - An accident involving the resident which results in injury;
    - A significant change in the resident's physical, mental, or psychosocial status;
    - A need to alter treatment significantly.
- Residents have the right to be fully informed of their health status, including but not limited to their medical condition. This further includes the right to be fully informed in advance about care and treatment and any changes that may affect the resident's well being.
- Conduct care planning sessions with resident and family/representative involvement on an ongoing basis, to discuss such changes or to update a resident's care plan.
- Facilities investigate and report to the DQA, within 24 hours, any allegations involving possible abuse, neglect, misappropriation of property, or injuries of unknown sources.
- Any survey allegation involving possible Substandard Quality of Care (SQC) requires the facility to provide DQA with the names and contact information for the attending physicians of residents possibly impacted. DQA then provides notice to these physicians.

- Unexpected deaths must be reported to the coroner.
- Adhere to the adult-at-risk reporting requirements if any physical or financial exploitation is suspected.

If the purpose of AB 389 is to provide residents and families with information to allow their enhanced dialog with the facility to address care or service concerns, the provision of survey information comes long after expected notification and communications have already occurred. If however, the purpose is to assign blame as to non-compliance, then surely, the facility should be afforded the full opportunity to contest the allegations before being compelled to provide such notice.

All survey results, including IJ and Class A violations, must be posted and are accessible to the public:

Similarly, the state and federal regulations mandate that nursing homes to post survey results and advocacy contact information. Furthermore, there are expanding consumer information resources that report facility compliance history and performance.

- Survey results must be posted in a prominent place within the facility for anyone to review. In addition, CMS continues to enhance its Nursing Home Compare website, which predominantly focus on survey information.
- The Consumer Information Report must be provided to anyone considering placement at a facility or who simply requests the report.
- Notices are required to be provided and posted that residents have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies. Residents and their families are provided and encouraged to make contact with advocacy agencies, e.g. the Ombudsman Program, should they have concerns that cannot or have not been addressed by facility personnel.

Pragmatic, Logistical, and Privacy Issues:

There are pragmatic, logistical and privacy concerns for the expectations contained within the bill which requires the nursing home, within 15 days, to provide notice that includes (1) the copy of the SOD, (2) the anonymous identifier used to designate the resident in the SOD, and (3) the contact information for the regional survey office.

This will compel a facility to send multiple versions of what can be a lengthy document that is already posted for review, and available upon request. In some cases, such as an infection control allegation, this may need to go to every resident that was at the facility during the period of alleged non-compliance. As discussed previously, there is already an obligation to notify residents/representatives of changes, accidents, etc. This bill would essentially require further notification of information already possessed and available to residents and their representatives.

To disseminate the anonymous resident identifier along with the SOD will further create a potential privacy issue, as each resident will have to receive a different version, with all the other residents identified being redacted (see attachment as example). While nursing homes are diligent with respect to their privacy and confidentiality obligations, the paperwork required to complete the expected task, coming during the same window in which facilities are expected to be conducting corrective efforts, completing Plans of Corrections, and possibly preparing for IDR/appeal, exposes facilities and residents to needless opportunities for data breaches.

Conclusion:

The above are significant issues and basis for opposition to this bill, but as importantly, the proposed requirements will do nothing to further quality improvement. Compelling facilities to undertake significant workload, at a time when resources are scare and staff should be completing the tasks of addressing the alleged non-compliance, will actually take away from quality efforts. There are already lines of communications that are either required or conducted in the normal course that provides residents and families with opportunities to discuss what may have occurred and what steps the facilities have taken to address issues and concerns. Sending documents that are (1) intended for certification and licensing purposes, (2) possibly months after the fact, and (3) not fully representative of the complete picture, does nothing to towards quality care and will serve only to harm facilities and possibly the residents/family.

For the reasons articled above, the WHCA requires that the committee members oppose AB 389.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
OQA-2552 (Rev. 01/08)

STATE OF WISCONSIN

STATEMENT OF DEFICIENCIES IDENTIFIER KEY

CONFIDENTIAL - DO NOT POST.

Name - Facility	City - Facility	License / Facility Number
[redacted] Center, LLC	[redacted]	[redacted]
Survey Type	**Exit Date (mm/dd/yyyy)**	**SOD Number(s)**
CHOW, V.V., Entity Self Report; Partial Extended	01/28/09	[redacted]

Resident, Patient, Tenant, or Client (Identify with a number.)		**Staff, Complainant, or Family Member** (Identify with an alphabetical character.)		
Identifier	Name	Identifier	Name	Staff Position or Relationship to Resident, Patient, etc.
[redacted]	[redacted]	NHA	[redacted]	Administrator
[redacted]	[redacted]	DON	[redacted]	Director of Nursing
[redacted]	[redacted]	A	[redacted]	LPN
12.	Ethel [redacted]	B	[redacted]	LPN
[redacted]	[redacted]	C	[redacted]	LPN
[redacted]	[redacted]	D	[redacted]	RN
[redacted]	[redacted]	E	[redacted]	RN
[redacted]	[redacted]	F	[redacted]	Primary MD/Fac.Med.Director
[redacted]	[redacted]	G	[redacted]	RN
[redacted]	[redacted]	H	[redacted]	Corporation's Clinical Nurse
[redacted]	[redacted]	I	[redacted]	CNA
		J	[redacted]	RN

☐ **Check here if there is an additional page to this identifier key. Complete the header information at the top of each page.**

STATE OF WISCONSIN
BOARD ON AGING AND LONG TERM CARE
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
(608) 246-7013
Ombudsman Program (800) 815-0015
Medigap Helpline (800) 242-1060
Fax (608) 246-7001
http://longtermcare.state.wi.us

TESTIMONY
of William P. Donaldson.
Counsel to the Board on Aging and Long Term Care
In Support of AB 389

Thank you, Rep. Krusick and members of the Committee for listening to the comments of the Board on Aging and Long Term Care (BOALTC) on this important bill.

The Long Term Care Ombudsman Program operated by BOALTC has, as a significant part of its functional mandate under the federal Older Americans Act, a responsibility to educate and inform residents of long term care facilities and their families on issues of concern to them. These issues include residents' rights and concerns relating to regulatory activities in the resident's home.

Residents and their families often specifically inquire about the survey process, where they can locate the results of that process (the Statement of Deficiency [SOD]), and how to interpret that document. In many cases, the families are surprised and even outraged that they are hearing a detailed description of an event for the first time. The families sometimes indicate that they have been told that "something happened," or that "there was a little mishap," or that "Dad fell out of bed when no one was there." However, these stories lacked the detail that was made available to the investigators and, in some cases, there is little resemblance between the initial complaint and the investigation report. This is wrong and the "smoothing over" of events that cause harm or may cause harm to residents cannot be allowed to be the norm.

A fundamental premise of the Long Term Care Ombudsman Program is that transparency is a basic right of residents. This transparency extends to all aspects of a resident's life in the facility. It has been our position, developed from experience, that the appearance of a cover-up caused by a lack of disclosure of an untoward event until a DQA investigation has been completed may actually do more to arouse a family's suspicion and resentment than will an honest, straightforward and complete discussion of the incident and ways to avoid its recurrence.

In any event, we believe that it is the right of residents and their family members to have timely notice that the resident has been at the center of an investigation by the regulatory authority of the state and to know the cause and the outcome of that investigation as soon as possible. AB 389 will do much to achieve this result.

Thank you for your attention. At this time I would be happy to answer any questions that the Committee may have.

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Thomas G. Cannon
Executive Director

September 10, 2009

State Representative Peggy Krusick
Chair, Committee on Aging and Long-Term Care
State Capitol, Room 128 North
PO Box 8952
Madison, WI 53708

Re: Assembly Bill 389

Dear Representative Krusik:

For the past 11 years, I have been Coordinator of the GAIN Project at the Legal Aid Society of Milwaukee. GAIN stands for Guardian, Advocacy, Instruction, and Networking Project. It is my responsibility to recruit, train, and assist volunteers to act as a legal guardian for individuals who have been adjudicated incompetent by the Probate Court. We have approximately 275 volunteers who serve as guardians for nearly 600 wards in the GAIN Project.

Our wards range in age from 18 to 96 years. Each suffers from a major disability such as degenerative brain disorder, developmental disability, mental retardation, traumatic brain injury, or chronic mental illness, any one of which renders them unable to make their own decisions. Wards need a guardian to advocate on their behalf. Most of them have no family or friends involved in their life; their guardian is the only person who visits them on a regular basis. Most of our wards are elderly and live in nursing homes in Milwaukee County.

I support Assembly Bill 389, which requires that notification of nursing home violations be given to residents and their legal guardians, for a number of reasons. Residents in nursing homes are some of the most vulnerable people in our society. They are dependent on others to provide all of their daily wants and needs. It is up to their families or guardians to ensure that they are safe and well-cared for. Guardians are required to act as their advocate in a variety of situations. Duties are set out in Wis. Stats. s. 54.25. How can a guardian advocate on behalf of his or her ward if s/he is not informed that the ward is at risk of serious harm or injury? Nursing homes must be required to give guardians notice of significant violations.

The guardian needs to be informed of the incident, the identifier that is used to represent their ward, the contact information for the unit investigating the allegation, and a report of the final disposition. This is a basic consumer protection right that should be given to all nursing home residents and their guardian.

Mandating that nursing homes notify the resident, and their legal representative, is the first step in holding negligent providers accountable. It also provides a means to bring harmful or serious violations to light. It is essential that an incident be documented so that the designated advocate can become aware of the violation and take whatever action is necessary to protect the nursing home resident. Depending on the severity of the violation, such notice allows the decision-maker an opportunity to explore other options for their nursing home resident, perhaps an alternate placement or one that can provide a safer environment.

As Coordinator of the GAIN Project, I require guardians to report serious injuries to their wards that are being investigated for possible abuse. Guardians learn of these allegations in one of several ways: (1) from staff who are willing to share that information because of the relationship that has formed between the staff person and the guardian, (2) from reading a nursing note in the ward's health record, or (3) by repeatedly asking questions of the resident or staff. This information should be provided to them firsthand so that they are able to make informed and immediate decisions regarding the care and welfare of the resident on behalf of whom they have been entrusted to advocate. Guardians need to be able to make informed decisions that are in the best interest of the resident. This can only be done if the guardian is aware a problem exists.

Passage of Assembly Bill 389 is the right decision for Wisconsin nursing home residents. It will provide an extra level of protection to some of our most vulnerable individuals.

Thank you for providing this opportunity to comment.

Very truly yours,

Diana Pitkaranta
GAIN Project Coordinator

disabilityrights | WISCONSIN

Testimony In Support of AB 389
Lynn Breedlove, Executive Director
Disability Rights Wisconsin
September 10, 2009
Assembly Committee on Aging and Long-Term Care

Disability Rights Wisconsin strongly supports AB 389, which would require nursing homes that receive a written notice of a Class "A" violation or a federal deficiency indicating immediate jeopardy to provide to each nursing home resident identified in the citation (and their legal representative) written notice of the finding within 15 days. This is an important bill that will expand communication and transparency in the care of vulnerable individuals.

Consumers of care and their legal representatives have the right to know of serious incidents within nursing homes immediately after regulatory actions. Expecting consumers to wait until survey results are published after inspections conducted only once every two years is inadequate. This bill is limited to the most serious violations and will provide reassurance to consumers and their families that serious situations have been noted, cited and what the plan for correction will be to prevent against future incidents.

In our 30 years of responding to allegations of abuse and neglect in facilities that provide care to people with disabilities throughout Wisconsin, we have seen residents and their families given inadequate or no information about significant events. "She just fell," or "we had a little problem with a new staff member" or "he just didn't ask for help soon enough" leave vulnerable consumers and their families and representatives in the dark and frightened. They don't know what happened or why. They don't know whether anyone in authority has investigated or responded to the situation. This is especially critical in situations where a resident him or herself may no longer have the capacity to identify the need for assistance or seek outside intervention.

This reasonable bill requires notification of only of the most serious situations and that result in regulatory actions. Passage of this bill will provide consumers and their legal representatives with critical information rather than fuel suspicions, worries or cover-ups.

We urge swift approval of AB 389.

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AARP

The power to make it better.

September 10, 2009

TO: Assembly Aging and Long-Term Care Committee

FROM: Lisa Lamkins, AARP Wisconsin Advocacy Director

RE: Support for AB 389 Nursing Home Violation Reporting Bill

AARP Wisconsin supports AB 389, the Nursing Home Violation Reporting Bill.

AB 389 would require families to be notified when their loved one in a nursing home is included in a serious state citation by the Department of Health Services following an inspection of that nursing home.

Today consumers have access to some information about nursing home violations, but they have no way of knowing if their family member is included in that violation.

Choosing a nursing home is a very important decision for families. Many families use a variety of resources to compare the quality of nursing homes they are considering. AARP and other consumer organizations provide useful checklists of things to consider when selecting a nursing home so that families can make the best decision possible.

But these steps mean very little if family members don't get timely information about how their loved one is treated as a resident of a facility. If a nursing home is cited for a serious violation after something bad happens to a resident, then the family of that resident has a right to be notified.

Nursing homes should be a place where loved ones get the high quality care they need. If that is not the case, then family members need to know. AB 389 would make it easier for families to get this important information.

AARP Wisconsin urges Committee members to pass Assembly Bill 389 so Wisconsin families can get the information they need to keep their loved ones safe in nursing homes.

Thank you for your consideration.

For more information, contact: Lisa Lamkins, AARP Wisconsin Advocacy Director at 608-286-6302 or llamkins@aarp.org

Wisconsin Association of Homes and Services for the Aging, Inc.
204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

September 10, 2009

To: Representative Peggy Krusick, Chair
Members, Assembly Aging and Long-Term Care Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: **WAHSA Opposition to 2009 Assembly Bill 389**

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership association of 184 *not-for-profit* long-term care organizations. For purposes of AB 389, WAHSA members own, operate and/or sponsor 183 not-for-profit nursing homes, including 41 county-operated and 7 municipally-operated facilities. In addition, WAHSA members operate 77 community-based residential facilities (CBRF), 63 residential care apartment complexes (RCAC), 113 senior apartment complexes/retirement homes for the aged, as well as over 300 community service programs ranging from Alzheimer's support, child and adult day care, home care and hospice to Meals on Wheels. WAHSA members employ over 38,000 dedicated staff who provide care and services to over 48,000 residents/tenants/clients. WAHSA members are a key component of the Wisconsin nursing home sector which collectively contributes approximately $5.2 billion annually to the State's economy through job creation, tax revenue, and purchased goods and services.

WAHSA members oppose AB 389 because it denies them their due process rights, because it could unduly mislead those it seeks to inform, and because it focuses staff time on paper reproduction rather than improved resident care.

AB 389 requires a nursing home which receives a State Class "A" notice of violation (NOV) or a federal statement of deficiency (SOD) indicating a finding of "Immediate Jeopardy" (IJ) to provide written notice to each resident identified in the NOV/SOD, as well as to the resident's legal representative, if any, within 15 days of the receipt of the violation notice. The written notice must include a copy of the Class "A" NOV and/or the IJ SOD, as well as the anonymous identifier used to identify the resident in the NOV/SOD and the address, telephone number, and e-mail address of the regional office of the Department of Health Services (DHS) Division of Quality Assurance (DQA) in the region where the facility is located. Upon the request of the resident and/or his/her legal representative, the DQA will provide them with the final disposition of the Class "A"/IJ allegations once the appeals process runs its course.

A Class "A" violation under s. 50.04(4)(b) is defined as "a violation of this subchapter or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a nursing home presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom." Under s. 50.04(4)(c)1, "the situation, condition or practice constituting a Class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the department and specified in the notice of violation, is required for correction." (emphasis added). If the Class "A" violation is not abated or eliminated within the specified period of time, "the department shall maintain an action in circuit court for injunction or other process against the licensee, owner, operator, administrator or representative of the facility to restrain and enjoin violation of applicable rules, regulations and statutes." A Class "A" violation may be subject to a forfeiture of not more than $10,000 for each violation.

Under federal code, an "immediate jeopardy to resident health or safety" is a "deficient practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future. Immediate corrective action is needed." If there is a finding of "immediate jeopardy to resident health or safety," the State must either terminate the facility's Medicaid/Medicare provider agreement within 23 calendar days of the last date of the survey or appoint a temporary manager to remove the IJ. In addition, the facility also could face civil money penalties (CMP) of between $3,050 and $10,000 for each day the facility was in violation.

Stated simply, a Class "A" NOV or a SOD with a finding of "immediate jeopardy" are serious nursing home violations which must be addressed immediately and may subject a facility to significant penalties.

Representative Krusick last year convened a work group of consumers, advocates, providers and representatives of the DHS and the Board on Aging and Long-Term Care to discuss the issue of notification of serious violations as well as other issues which were raised in the July 26-28, 2008 *Milwaukee Journal Sentinel* series Unsafe Haven: A Watchdog Report on Troubled Nursing Homes. The work group met on August 28, 2008. The discussion revolved around whether current nursing home notification requirements were adequate. Representatives of the DQA distributed the attached memo "Applicable Requirements for Communication Between Nursing Home Personnel and Residents/Families/Legal Representatives." That memo indicates that under 42 CFR 483.10(b)(11)(A)-(C), in the event of an accident involving a nursing home resident that could result in physician intervention, a significant change in the resident's physical, mental or psychosocial status, or a need to alter the resident's treatment significantly, a facility must IMMEDIATELY inform the resident, notify any legal representative or interested family member, and consult with the family's physician. In addition, DHS 132.60(3)(a) requires that a resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified must be notified by the facility PROMPTLY of any significant accident, injury, or adverse change in the resident's condition. Finally, federal regulations under 42 CFR 483.10(g) give each nursing home resident the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results

available for examination in a place readily accessible to residents, and must post a notice of their availability.

WAHSA members believe that the current federal and state notification requirements outlined in the attached DQA memo provide a resident, the resident's legal representative, if any, and any designated family members with sufficient and timely notification of any adverse circumstances impacting that resident. The real issue, therefore, must not be the notification of an adverse circumstance; it must be who to blame for that adverse circumstance.

AB 389 requires notification of a Class "A" NOV or a SOD with an IJ finding within 15 days after receipt of the violation notice. **What the bill chooses to ignore is the facility's due process rights**.

The first step in the nursing home due process system is the Informal Dispute Resolution (IDR), an abbreviated review of the federal SOD or state NOV. IDRs are conducted by the Michigan Peer Review Organization (MPRO), a third-party contractor with the DHS. A facility has 10 days after the receipt of a NOV/SOD to request an IDR and to submit supporting materials challenging the survey findings to MPRO. If a facility chooses to "IDR" a violation, MPRO schedules either a "desk review" of the challenge or conducts the review by phone. MPRO must submit its recommendations on the IDR to the DQA no later than 21 days from the facility's original receipt of the SOD/NOV.

Facilities also have the right to appeal a federal remedy (i.e., civil money penalties, denial of payments for new admissions, etc.) to the Centers for Medicare and Medicaid Services (CMS) no later than 60 days after the imposition of the remedy. The final resolution in this case could take several months. In addition, facilities can challenge state citations. In that case, the facility has 10 days after the receipt of the NOV to request a hearing with the Division of Hearings and Appeals. Statutes require the hearing to be conducted within 30 days of the request but usually this hearing is put on hold pending the issuance of a forfeiture for the violation. The receipt of that forfeiture could come months after the NOV has been received; there have been circumstances where the forfeiture was received over 2 years after the NOV was received. If the facility chooses to appeal the forfeiture, a case conference generally is scheduled with the DHS Office of Legal Counsel to either narrow the issues or find a solution. If neither is forthcoming, an administrative hearing on the forfeiture and the NOV is generally the final step in the process. Typically, the time between the issuance of the NOV and the final appeals disposition is over one year.

By requiring the notification of a Class "A" or IJ finding within 15 days of the receipt of the violation, AB 389 denies nursing home providers their due process rights. The Class "A" NOV or IJ finding are allegations of violations; as noted above, they can be challenged and they can be changed. AB 389 ignores those rights and requires the notification in spite of them. **It equates to an arrested man being required to admit guilt before the trial and the jury's verdict**. And while it's unfair to the provider, the AB 389 notification requirement could be terribly misleading to the resident and family members if the Class "A" and/or IJ violations were

later reduced (it's highly unlikely, but still possible, that such serious violations would be dropped or overturned). How, then, has this information been of benefit to them?

WAHSA members also object to the 15-day notification timeframe under AB 389 because it places the emphasis on paper pushing rather than resident care. As noted above, facilities with these serious violations facing them are under the gun to come into compliance. They don't have time to make copies of NOVs/SODs, which could be as many as 200 pages in length; they're doing everything in their power to correct the deficiencies that were cited. And if the violation is in the area of infection control or other areas that could potentially impact every resident of the facility, the paper reproduction burden could be daunting because every resident and their legal representative would be required to be notified. **The question is whether staff time is better spent bringing the facility back into compliance or reproducing and redacting allegations of violations. WAHSA members believe it's in the residents' best interest to rectify the facility's care problems before undertaking any other actions.**

Thank you for this opportunity to provide testimony on AB 389.

Applicable Requirements for Communication Between Nursing Home Personnel and Residents/Families/Legal Representatives

Federal Rules

42 CFR 483.10

F157. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)…

F154. The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

F168. A resident has the right to: Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

State Law Requirements

s. 50.09(1)(n). Every resident in a nursing home or community based residential facility shall…have the right to…(n) Be fully informed of the resident's treatment and care and participate in the planning of the resident's treatment and care.

Nursing Home Administrative Code Requirements

HFS 132.60(3)(a). A resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified shall be notified promptly of any significant accident, injury, or adverse change in the resident's condition.

HFS 132.60(3)(b). A resident's guardian and any other person designated in writing by the resident or guardian shall be notified promptly of any significant non-medical change in the resident's status, including financial situation, any plan to discharge the resident, or any plan to transfer the resident within the facility or to another facility.

AARP[SM]

The power to make it better.[®]

September 10, 2009

TO: Assembly Aging and Long-Term Care Committee

FROM: Lisa Lamkins, AARP Wisconsin Advocacy Director

RE: Support for AB 389 Nursing Home Violation Reporting Bill

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Choosing a nursing home is a very important decision for families. Many families use a variety of resources to compare the quality of nursing homes they are considering. AARP and other consumer organizations provide useful checklists of things to consider when selecting a nursing home so that families can make the best decision possible.

But these steps mean very little if family members don't get timely information about how their loved one is treated as a resident of a facility. If a nursing home is cited for a serious violation after something bad happens to a resident, then the family of that resident has a right to be notified.

Nursing homes should be a place where loved ones get the high quality care they need. If that is not the case, then family members need to know. AB 389 would make it easier for families to get this important information.

AARP Wisconsin urges Committee members to pass Assembly Bill 389 so Wisconsin families can get the information they need to keep their loved ones safe in nursing homes.

Thank you for your consideration.

For more information, contact: Lisa Lamkins, AARP Wisconsin Advocacy Director at 608-286-6302 or llamkins@aarp.org

Applicable Requirements for Communication Between Nursing Home Personnel and Residents/Families/Legal Representatives

Federal Rules

42 CFR 483.10

F157. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)...

F154. The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

F168. A resident has the right to: Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

State Law Requirements

s. 50.09(1)(n). Every resident in a nursing home or community based residential facility shall...have the right to...(n) Be fully informed of the resident's treatment and care and participate in the planning of the resident's treatment and care.

Nursing Home Administrative Code Requirements

HFS 132.60(3)(a). A resident's physician, guardian, if any, and any other responsible person designated in writing by the resident or guardian to be notified shall be notified promptly of any significant accident, injury, or adverse change in the resident's condition.

HFS 132.60(3)(b). A resident's guardian and any other person designated in writing by the resident or guardian shall be notified promptly of any significant non-medical change in the resident's status, including financial situation, any plan to discharge the resident, or any plan to transfer the resident within the facility or to another facility.